Documentation and Justification for Compliance and Reimbursement

If it is not documented…
it did ***not*** happen!

In this session…

- Review of general OP&P documentation requirements
- Documentation requirements specifically associated with Medicare's TSD program
- HIPAA
- Fraud and Abuse

Documentation Review

- All necessary paperwork in chart
  - Review checklist
  - No exceptions
- All patient-related encounters get documented
  - Patient visits
    - In office
    - In clinic
    - In home
    - In short- or long-term care facility
  - Patient phone calls
    - Incoming
    - Outgoing
  - Other phone calls and conversations
    - Insurance companies
    - Physicians, PTs, family members, lab, etc.

Documentation Review

- Documentation needs to be thorough, complete and accurate.
  - Justify medical necessity / coding
    - Example: Medicare - A5501 (custom shoes) Is covered when “patient has a foot deformity that cannot be accommodated by a depth shoe. Documentation in the records must support the *nature and severity* of the deformity. Insufficient documentation will default coverage to the A5500.”
  - Audit or lawsuit
  - What if you get hit by a car?
    - Your fellow practitioners should be able to read through your notes, follow your thought process and pick up right where you left off.

Documentation Review

- Under CMS required standards
  - Uniform documentation includes but is not limited to: 1) professional staff member evaluation of the patient, which should contain diagnosis request for care, relevant patient history, assessment, patient education and medical necessity; 2) pre-treatment photographic documentation as appropriate for the item; and 3) the name of the attending practitioner, their findings, recommendations and treatment plan for a specific course of care and management as well as the appropriate follow-up schedule.
  - The organization is also expected to document patient-specific goals and expected outcomes for use of the pedorthic device. Prior to final delivery, the organization assesses the device for for structural safety and ensures that the manufacturer's guidelines are followed.
  - Evidence of patient education must be recorded and must include: 1) purpose and function of device; 2) proper care and use; 3) disclosure of risks, benefits and precautions; 4) how to report problems and to whom.

O,P&P-specific Medicare Guidelines

- Intake
  - In addition to the requirements described in the General Product-specific Services Requirements, the supplier shall:
    - Comply with CMS regulations and Medicare contractor policies and articles
    - Perform a diagnosis-specific clinical examination
    - Collect pre-treatment photographic documentation as appropriate
    - Assess the item for structural safety and ensure that the manufacturer guidelines are followed prior to fitting/delivery; and
    - Assure the implementation plan is consistent with the prescribing physician's written plan of care

O,P&P-specific Medicare Guidelines

- Beneficiary Record
  - In addition to the requirements described in the General Product-specific Services Requirements, the supplier shall:
    - Establish goals and expected outcomes for the beneficiary
    - Solicit feedback from the beneficiary, and physician as necessary, to determine the effectiveness of the items
    - Communicate to the beneficiary and/or prescribing physician the recommended treatment plan and any optional plans, including disclosure of potential risks/benefits involved
    - Consult with the prescribing physician before finalizing the service plan if it differs from the original order
    - Refer the beneficiary back to the prescribing physician for intervention or treatment beyond supplier's scope of practice

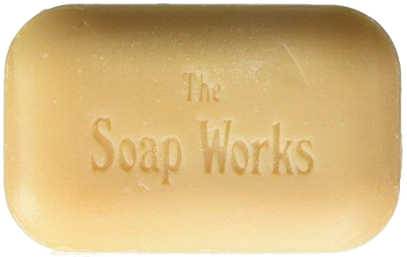
O,P&P-specific Medicare Guidelines

- Training/Instruction to Beneficiary and Caregiver
  - In addition to the requirements described in the General Product-specific Services Requirements, the supplier shall provide instructions to the beneficiary and/or caregiver for the specific items and devices as follows:
    - Review care and maintenance instructions
    - Provide necessary supplies (e.g. adhesives, solvents, lubricants) to attach, maintain, and clean the items, as applicable, and information about how to subsequently obtain necessary supplies
    - Inspect and monitoring for complications
    - Reporting any problem to the supplier and/or referring physician of changes in condition or health

O,P&P-specific Medicare Guidelines

- Follow-up
  - In addition to the requirements described in the General Product-specific Services Requirements, the supplier shall:
    - Provide appropriate beneficiary follow-up care consistent with the items or services provided, the beneficiary's diagnosis, specific care rendered, and recommendations
    - Inform the beneficiary or caregiver of the procedures for repairing, replacing, and/or adjusting the device or items, the possible risks, and estimated time involved in the process
    - Have access to the equipment (or another provider who has it) necessary to modify or adjust the item
    - Advise the patient to make an appointment with the prescribing physician, as appropriate for use of the specific item or service

SOAP



- Subjective:
  - This describes the patient's current condition in narrative form. The history or state of experienced symptoms are recorded in the patient's own words. It will include all pertinent and negative symptoms under review of body systems. Pertinent medical history, surgical history, family history, and social history, along with current medications and allergies, are also recorded. If this is the first time a practitioner is seeing a patient, they will take a history of present illness, or HPI.
    - **O**nset
      Location
      Duration
      Character (sharp, dull, etc)
      Alleviating/**A**ggravating factors
      Radiation
      Temporal pattern (every morning, all day, etc)
      Symptoms associated
- Objective:
  - Findings from physical examinations, such as posture, deformities, gait deviations and abnormalities
  - Measurements, such as age, height, weight of the patient, ROM of joints, etc.
- Assessment:
  - Is a quick summary of the patient with main symptoms/diagnosis .
- Plan:
  - This is what the health care provider will do to treat the patient's concerns. A note of what was discussed or advised with the patient as well as timings for further review or follow-up may also be included.
  - Often the Assessment and Plan sections are grouped together.

Documentation Review

- Problem (Initial visit or return with new complaint/prescription)
  - What is the diagnosis on the prescription?
  - What did your evaluation reveal to you?
  - Patient's relevant medical history
  - Patient's pedorthic/orthotic medical history
    - What has been tried?
    - What, if anything, has worked why?
    - What hasn't worked and why?
  - Patient's occupational and activity-related requirements
  - Does patient have appropriate footwear?

Documentation Review

- Problem(Established patient)
  - Reason for appt.
    - Scheduled follow-up
    - Needs adjustment
    - Needs new device(s)
  - What is complaint?
  - Has device been properly used?
  - Has patient seen physician since last visit?
  - Other team-member input?

Documentation Review

- Action
  - Impetus for action
  - What action was taken?
    - Tried on shoes
    - Molded for AFO or TCIs
    - Modified AFO / TCI
    - Dispensed AFO / TCIs
  - How did it go?
  - Summarize discussion
    - Quote if important

Documentation Review

- Plan
  - Practitioner recommendations
  - Immediate practitioner plan
  - Specific objective goals of treatment
  - Expectations
  - Follow-up plan
  - Plan “B”, if necessary

Guidelines

- New patient visit notes must include the following:
  - Date
  - Where pt was seen and by whom
  - Referring physician
  - Pt's age, gender and occupation
  - Findings of physical exam (arch height, joint mobility, deformities, etc.)
  - Past pedorthic/orthotic history (what have they tried, what worked, what didn't, etc.)
  - Dx as stated on Rx
  - What is Rx for?
  - CPed explained Rx, reviewed the goals, function and benefits of prescribed device(s) and compared and contrasted to what they currently have or have used in the past
  - Was pt shown sample of ordered device(s)?
  - Reviewed footwear requirements for pt and for device(s)
  - All of the patient's questions were answered and they wish to proceed
  - Action taken (molds taken, tried on shoes, etc.)
  - Detailed plan
  - Specific treatment goal(s)
  - Sign note!

Guidelines

- Delivery appt notes must include the following:
  - Date
  - Where pt was seen and by whom
  - Note any change in patient's condition
  - List of items fit and dispensed, including vendor, item numbers and invoice
  - Items were as ordered (if not, explain why)
  - Practiced donning and doffing
  - Pt walked in items and patient's initial reaction
  - Any adjustment s made and why
  - Goals, benefits and function reviewed again
  - Usage, longevity and break-in process reviewed (detail break-in if needed)
  - Pt was instructed to discontinue use and contact us if they develop a problem with device(s)
  - All of pt's questions were answered and they expressed understanding of all that was discussed
  - Pt was given contact information
  - Pt was given printed wear and care brochure (For Medicare pts: Pt was given printed wear and care brochure with Medicare Supplier Standards)
  - Pt was given warranty information
  - Detailed follow-up plan
  - Other relevant info
  - Sign and date note!

Guidelines

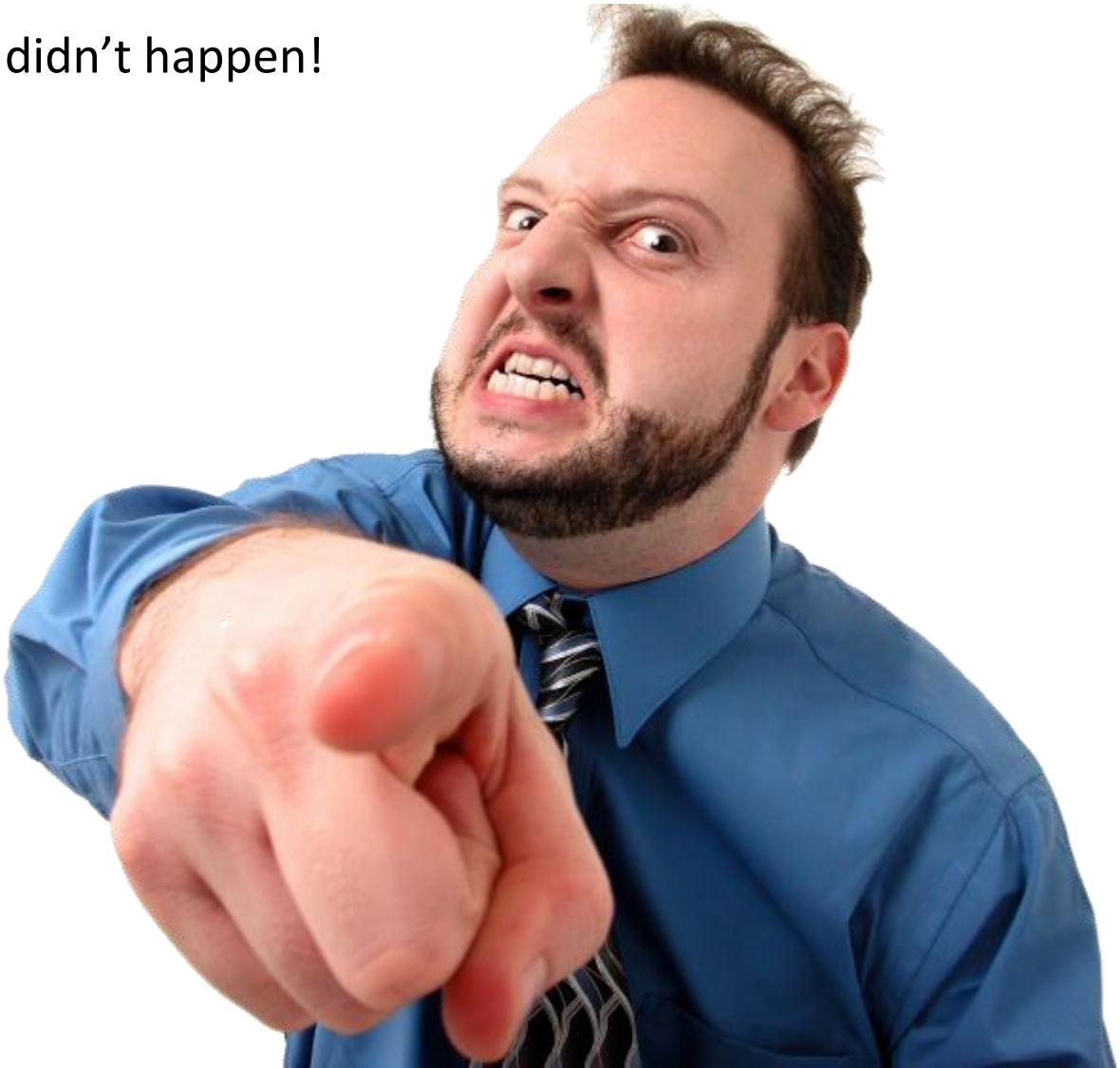
- Adjustment appt notes must include the following:
  - Date
  - Where pt was seen and by whom
  - How long have they had device(s)
  - Current complaint
  - New Rx?
  - Action taken
  - Patient’s initial assessment of adjustment(s)
  - Follow-up plan
  - Other relevant info
  - Sign note!

Documentation Review

- All handwritten documentation should be done in ***black*** ink
- All entries need to be signed and dated at the end
- Mistakes should be crossed out with a single line

Remember!!!

- If it isn’t documented…it didn’t happen!
- C.Y.A.



SWO Vs. Rx

Per Medicare…

- For DMEPOS items other than power mobility devices, someone other than the treating practitioner may complete certain required elements of the SWO; however, the SWO must be signed by the treating practitioner.
- Prescribing of DMEPOS is limited by Medicare regulations and by the treating practitioner's respective scope of practice as determined by the state wherein they practice. Chiropractors are not permitted to prescribe DMEPOS items.
- NEW ORDER REQUIREMENTS
  - A new order/prescription is required:
  - For all claims for purchases or initial rentals;
  - If there is a change in the DMEPOS order/prescription (e.g., quantity);
  - On a regular basis (even if there is no change in the order/prescription) only if it is so specified in the documentation section of a particular medical policy;
  - When an item is replaced;
  - When there is a change in the supplier, and the new supplier is unable to obtain a copy of a valid order/prescription for the DMEPOS item from the transferring supplier.

Standard Written Order

- A SWO must be communicated to the supplier prior to claim submission. For certain items of DMEPOS, a written order is required prior to delivery (WOPD) of the item(s) to the beneficiary (see below).
- A SWO must contain all of the following elements:
- Beneficiary's name or Medicare Beneficiary Identifier (MBI)
- Order Date
- General description of the item
    - The description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number
    - For equipment - In addition to the description of the base item, the SWO may include all concurrently ordered options, accessories or additional features that are separately billed or require an upgraded code (List each separately).
    - For supplies – In addition to the description of the base item, the DMEPOS order/prescription may include all concurrently ordered supplies that are separately billed (List each separately)
- Quantity to be dispensed, if applicable
- Treating Practitioner Name or NPI
- Treating practitioner's signature

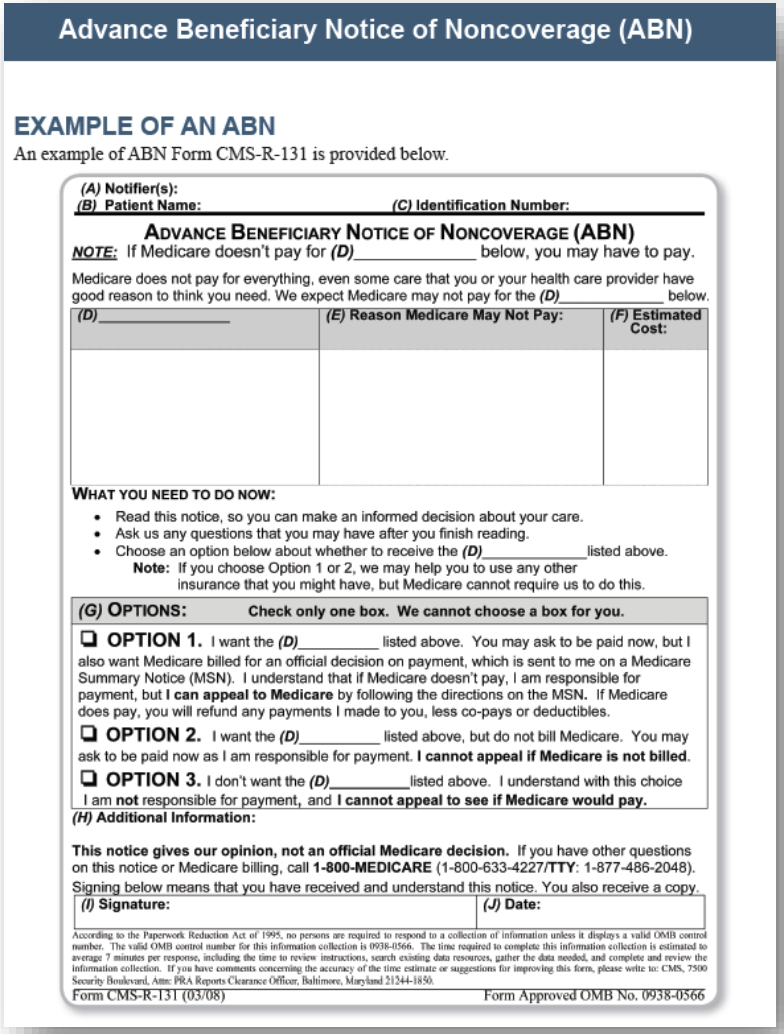
Prescription

- The prescription is the initial order from the referring physician.
- While Medicare does not technically consider the Rx to be part of the medical record, they do recommend having a Rx and consider it to be a “best practice”.
- ABC requires a Rx to be on file.
- The prescription should be considered an *authorization to begin treatment*.

Advanced Beneficiary Notice

ABN:
The Advanced Beneficiary Notice is used to convey that Medicare is not likely to provide coverage in a certain case. A verbal review should also take place far enough in advance so the beneficiary is able to consider the options and make an informed decision.

Once signed, the GA modifier can be affixed on the claim to require payment by the patient. If not signed or missing modifier, the patient is NOT financially responsible.



Advance Beneficiary Notice of Noncoverage (ABN)

EXAMPLE OF AN ABN

An example of ABN Form CMS-R-131 is provided below.

(A) Notifier(s):
(B) Patient Name: (C) Identification Number:

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for (D)_____ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the (D)_____ below.

(D)_____	(E) Reason Medicare May Not Pay:	(F) Estimated Cost:

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the (D)_____ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

(G) OPTIONS: Check only one box. We cannot choose a box for you.

❑ OPTION 1. I want the (D)_____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

❑ OPTION 2. I want the (D)_____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

❑ OPTION 3. I don't want the (D)_____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

(H) Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY**: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

(I) Signature:	(J) Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

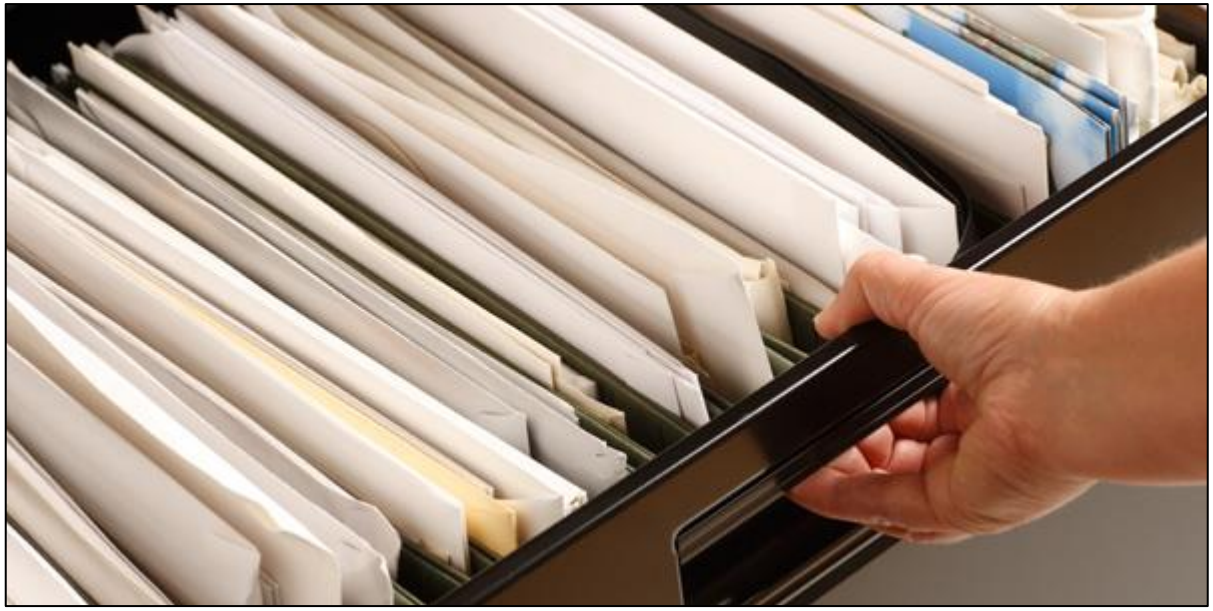
Form CMS-R-131 (03/08) Form Approved OMB No. 0938-0566

Medicare Beneficiary Complaint Log:

- The patient has the right to freely voice grievances and recommend changes in care or services without fear or reprisal or unreasonable interruption of services.
- Complaints need to be documented in the Medicare Beneficiaries Complaint Log.
- The log must contain the patient's name, address, telephone number, and health claim number, a summary of the complaint, the date it was received, the name of the person receiving the complaint, and summary of the actions taken to resolve the complaint.

Keep all documents for at least 10 years.

All documentation must be available to the DMERC upon request.



Modifiers:

- **KX-**Specific required documentation on file
- Must be appended to all claims for diabetic footwear
- **LT -**Left Side
- **RT -**Right Side
- **EY-**No physician or other licensed health care provider order for this item or service
- Use if there is not a completed order
- **GA-**Properly completed ABN on file (when applicable)

Medicare Benefit Policy Manual
Publication 100-02 Chapter 15 Section 20.3

“If a custom-made item was ordered but not furnished to a beneficiary because the individual died or because the order was canceled by the beneficiary or because the beneficiary’s condition changed and the item was no longer reasonable and necessary or appropriate, ***payment can be made*** based on the supplier’s expenses.”

Reimbursement is invoiced amount DOS will be date of cancellation
You will submit invoice with claim

Upgrades

- “An upgrade may be from one item to another within a single Health Insurance Common Procedure Coding System (HCPCS) code or may be from one HCPCS code to another. When an upgrade is within a single code, the upgraded item must include features that exceed the official code descriptor for that item.”
- While boots achieve the same medical benefit, they are more expensive and have additional features that can be considered an upgrade. The provider can bill the boot as an upgrade for the difference. A signed ABN is required in this instance.

Liability Insurance Requirements

- A provider of DMEPOS products must possess the following liability coverage:

- **Professional Liability**—this is liability insurance for the services which are rendered
- **Product Liability –** the liability for the devices or products dispensed from the office/clinic
- **Property/Casualty**—the protection of the storefront


HIPAA
Health Insurance Portability
and Accountability Act

HIPAA

- **HIPAA-** health insurance portability and accountability act of 1996, mandates the use of standards for the exchange of health care data.

- What is it?
- It is protection for the privacy and security of Protected Health Information (PHI). It is also the standardization of electronic data interchange in health care transactions.

HIPAA

- Covered entities may use PHI for the purposes of Treatment, Payment and health care Operations (TPO) without any special permission from the patient.

- *Special permission, called an authorization, must be obtained for uses and disclosures other than for TPO.*

HIPAA

- The purpose of HIPAA is to:
- Limit the unauthorized use and disclosure of PHI
- Give patients new rights to access their medical records and to know who else has accessed them
- Restrict most disclosure of health information to the minimum needed for the intended purpose
- Establish new criminal and civil sanctions for proper use or disclosure
- Establish new requirements for access to records by researchers and others

HIPAA

- In a healthcare setting, the patient has the:
- Right to a notice of the covered entity privacy practices
- Right to request restrictions and confidential communications concerning PHI
- Right to obtain access to protected health information for inspection and copying
- Right to obtain an accounting of certain disclosures
- Right to request amendment of PHI

Documentation tips

The Audit Proof Chart

- Assignment of Benefits (AOB) form
  - Must have signed AOB for each item before submitting a claim
  - This form authorizes payment to you for the services/items you provide for the beneficiary for all payer types, as well as the patient's permission to release medical information if it is required to process the claim
- Prescription(s)
  - Written orders (Rev. 30, 09.27.02): Written orders are acceptable for all transactions involving DMEPOS. Written orders may take the form of a photocopy, facsimile image, electronically maintained, or the original "pen-and-ink" document.
- CMNs, LMNs, and supporting physician's notes
- Proof of delivery
- Proof of provision of Medicare Supplier Standards
- Advanced Beneficiary Notice (ABN)
- Documentation to meet set requirements and sufficient to justify code selection

The Audit Proof Chart

- **Measuring Documentation:**
  - The in-person evaluation of the beneficiary by the supplier at the time of selecting the items that will be provided (refer to Non-Medical Necessity Coverage and Payment Rules, criterion 4) must include at least the following:
  - 1. An examination of the beneficiary's feet with a description of the abnormalities that will need to be accommodated by the shoes/inserts/modifications.
  - 2. **For all shoes, taking measurements of the beneficiary's feet.**
  - 3. For custom molded shoes (A5501) and inserts (A5513), taking impressions, making casts, or obtaining CAD-CAM images of the beneficiary's feet that will be used in creating positive models of the feet.
  - The in-person evaluation of the beneficiary by the supplier at the time of delivery (refer to Non-Medical Necessity Coverage and Payment Rules, criterion 5) must be conducted with the beneficiary wearing the shoes and inserts and must document that the shoes/inserts/modifications fit properly.

The Audit Proof Chart

- **Delivery Documentation:**
  - At the time of in-person delivery to the beneficiary of the items selected, the supplier must conduct an **objective assessment** of the fit of the shoe and inserts and document the results. **A beneficiary's subjective statements regarding fit as the sole documentation of the in-person delivery does not meet this criterion.**
  - If criteria 1-5 are not met, the therapeutic shoes, inserts and/or modifications will be denied as noncovered. When codes are billed without a KX modifier, they will be denied as noncovered.
  - The in-person evaluation of the beneficiary by the supplier at the time of delivery (refer to Non-Medical Necessity Coverage and Payment Rules, criterion 5) must be conducted with the beneficiary wearing the shoes and inserts and must document that the shoes/inserts/modifications fit properly.

Fraud & Abuse

Fraud and Abuse

- *Abuse* involves actions that are inconsistent with sound medical, business or fiscal practices. Abuse directly or indirectly results in higher costs to the Medicare program through improper payments that are not medically necessary.
- *Fraud* is an intentional deception or misrepresentation that someone makes, knowing it is false, that could result in the payment of unauthorized benefits. A scheme does not have to be successful to be considered fraudulent.

Fraud and Abuse

- What constitutes fraud and/or abuse?
  - Billing for services never rendered
  - Misrepresenting the services rendered
  - Misrepresenting the diagnosis to justify payment
  - Altering claim forms
  - Soliciting, offering or receiving a kickback, bribe or rebate
  - Secret unlawful agreements between supplier, beneficiary and/or other health care provider that results in higher costs to Medicare
  - Deliberately applying for more than one payment for the same service
  - Unlawfully completing a Certificate of Medical Necessity
  - Falsifying documents
  - Misrepresenting the place of service

Fraud and Abuse

- The False Claim Act
  - Fines of up to $10,000
  - Damages up to 3x amount of fraudulent submission
  - Up to five years in prison

Fraud and Abuse

- The Anti-Kickback Provisions of the Social Security Act
  - Fines of up to $25,000
  - Up to five years in prison

Fraud and Abuse

- Civil Monetary Penalties (CMP)
  - Fines of up to $50,000
  - Damages up to 3x amount of fraudulent submission

Fraud and Abuse

- The Racketeer Influenced and Corrupt Organizations Act
  - Criminal conviction: up to 20 years in prison
  - Civil conviction: Asset forfeiture

Fraud and Abuse

- The Health Insurance Portability and Accountability Act
  - Created a new crime known as Health Care Fraud
  - Up to ten years in prison
  - 20 years if serious bodily injury occurs
  - Life in prison if death occurs

Fraud and Abuse

- HHS-OIG
  - Can exclude a provider from *all* government paying programs

Summary

- If it isn’t documented, it didn’t happen.
- It is YOUR responsibility to make sure all documents are in order.
- Medicare doesn’t care if it you meant to do it or not.
- Check 7 for TSD.
- Always refer to the LCD if you have questions.

The End